MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02490

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Clarksville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: ANDERSON - CHARLES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	Single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years	Months	Days	If less than one day
67	----	----	... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: ---

FATHER
12. Name: Thomas Anderson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rosie Butler
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 5 1945 (month) (day) (year)
Cemetery or crematory: Hopkins Chapel
Location: Highland md (Howard Co
18. Funeral director: Robert L Snowden
Address: Rockville md

19. 3/2-5 19... E. Joyce Lord
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1945 at 5:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 21 1945 to March 2 1945 and that I last saw him alive on March 2, 1945

Immediate cause of death	DURATION
Cancer of bladder	known to us since Feb. 195
Chronic myocarditis	
Due to: -----	
Due to: -----	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Albert J. Winterode M. D. or other
Address: Crownsville, Maryland Date signed: 3/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02491

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co
City or town: Glen Burnie.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 5th Ave S
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Sarah Bailey

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: James Bailey
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct 21 1861

8. AGE:

Years	Months	Days	If less than one day
83	4	26	____ hrs. ____ min.

9. Birthplace: Frederick Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home

FATHER
12. Name: John Owens
13. Birthplace: Frederick Md

MOTHER
14. Maiden name: Hanner Montgomery
15. Birthplace: Frederick. Md.

16. Informant: Saml. Bailey.
Address: Glen Burnie. Md

17. Funeral, Cem. A.A.C. Date thereof: March 21. 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Funeral Cemetery
Location: near Glen Burnie Md

18. Funeral director: Thos Singleton
Address: Glen Burnie Md

19. 3/20/1945 Mae Alba Dep Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1945, at 10 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945, to Mar 18 1945
and that I last saw h... alive on Mar. 18 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage.	4 days.
Due to: Senile Arteriosclerosis	8 years
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James S. Bellangelo M.D.
M. D. or other
Address: Glen Burnie Md Date signed: Mar 20, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (103)

02492

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Near Millersville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Crownsville Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chesterfield Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Henry G. Brettenitz

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Camelia Brettenitz (nee Liebold) 6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): April 13- 1866

8. AGE:

Years	Months	Days	If less than one day
78	10	28	...hrs. ...min.

9. Birthplace: Dosenitz, Germany (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Owner.

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mrs. Henry G. Brettenitz
Address: Crownsville, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 14 '45 (month) (day) (year)

Cemetery or crematory: St. Stevens Church yard

Location: Chesterfield Road A.A.Co.

18. Funeral director: Thad. W. Singleton, M.D.S.

Address: Glen Burnie, Md.

19. 3/13/1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1945 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15- 1944, to March 11- 1945 and that I last saw h... alive on March 10- 1945.

Immediate cause of death	DURATION
(a) Coronary Thrombosis,	1 day
Due to	
Due to	
Due to Carcinoma Rectum	8 mo.
Other conditions Dropsy	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Glen Burnie Md. Date signed: March 12- 45

VS/A15 (4)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

02493

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 10 days
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 8 hours, 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Conn County: Fairfield
City or town: Newton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Brushy Hill Road, P.O. Box 127
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME John H. BURNIE ASN: 31459425

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence I. Burnie
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): September 4, 1907

8. AGE: Years	Months	Days	If less than one day
37	5	26	— hrs. — min.

9. Birthplace: Westport, Conn. (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Alice M. (unknown) Burnie
15. Birthplace: Unknown

16. Informant: Service Record
Address: U.S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar 3, 1945 (month) (day) (year)
Cemetery or crematory: Kyle & Hull Undertakers
Danbury, Conn.
Location: Howard M. Blight Jr.
18. Funeral director: Howard Blight Jr.
Address: 4914 Belair Road, Baltimore, Md.

19. March 2 (Date rec'd by registrar) 19 45 W J Lawson Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 19 45 at 5:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 45 to March 2 19 45 and that I last saw him alive on March 2 19 45

Immediate cause of death	DURATION
Meningococcus, meningitis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: Confirmed as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury — Injured at work? —

23. SIGNATURE: Edward J. Kenney 1st Lt. MC M. D. or other
Address: Reg. Hosp, Ft. Meade, Md. Date signed: Mar 2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02494 28

Reg. Diat. No.

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 1 month, 15 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 yrs. 1 month, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #512
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME
BURNS - THOMAS

3.(b) Social Security Number
---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): April 11, 1917

8. AGE: Years	Months	Days	If less than one day
27	11	7	---- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: ----

FATHER
12. Name: Clarence Burns
13. Birthplace: Maryland

MOTHER
14. Maiden name: Selena Greene
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: Mar. 21, 1945
(month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City

18. Funeral director: Elroy C. Wilson
Address: 1000 Brantley Ave., Balto., Md.

19. March 19 1945 E. T. Joyce Rose
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1945, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 3 1944, to March 18 1945
and that I last saw him alive on March 18 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 2/23/44
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Albert V. Thompson M. D. or other

Address: Crownsville, Maryland Date signed: 3/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

02495

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 yrs, 9 mos, 21 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 31 yrs., 9 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Egypt Post Office
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: BUTLER - BELLE

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Philip Moore (common-law husband) 6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years	Months	Days	If less than one day
65	unknown		--- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: farm hand
11. Industry or business: ---

FATHER
12. Name: Tom Butler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lucy Hampton
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville, Md.

19. Funeral director: Supt.
Address

19. March 6 1945 — E. F. Joyce - Local Registrar (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 19 45 at 6:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1913 19 to March 4 19 45
and that I last saw her alive on March 4 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 3½ yrs.
Due to: ---
Due to: ---
Other conditions: Imbecility — over 31 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ---
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Hal J. Hancock M. D. or other
Address: Crownsville, Maryland Date signed: 3/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

02496

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: EastPort Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years
Hospital, institution, or street address where death occurred:
411 Chesapeake Ave.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: East Port Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 411 Cheasapeake Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Herbert Hillary Butler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Regina Doris Butler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 2, 1912

8. AGE: Years	Months	Days	If less than one day
32	3		hrs. min.

9. Birthplace: East Port Md. A. A. Co. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: None

FATHER
12. Name: Ernest Butler
13. Birthplace: A. A. Co Md.

MOTHER
14. Maiden name: Minty Snowden
15. Birthplace: East Port Md.

16. Informant: Mrs Minty Butler
Address: 411 Chesapeake Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/19/45 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: West St. Extd.

18. Funeral director: Ethel L. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Mar. 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1945, at 12 noon M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 12 1945, to March 15 1945 and that I last saw h[illegible] alive on March 15 1945

Immediate cause of death	DURATION
Acute Lobar Pneumonia	4 Days
Due to: Pneumonia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed 3/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

02497

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred:
U.S.N.Hospital, Annapolis, Md.
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Porter Road
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: Evelyn Loretta CARY

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 30, 1880

8. AGE: Years	Months	Days	If less than one day
64	8	8	...hrs. ...min.

9. Birthplace: New Orleans, La. (Town, county, and state)
10. Usual occupation: Widow
11. Industry or business:
FATHER 12. Name: David E. PURSELL
13. Birthplace: New Orleans, La.
MOTHER 14. Maiden name: Emma SWETTENHAM
15. Birthplace: New Orleans, La.
16. Informant: U.S.Naval Hospital
Address: Annapolis, Maryland
17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 9 1945 (month) (day) (year)
Cemetery or crematory:
Location: New Rochelle, New York.
18. Funeral director: B. L. Topping
Address: Annapolis, Md.
19. Mar 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8, 1945 at 5:48 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 1945, to March 8, 1945 and that I last saw her alive on March 1945

	DURATION
Immediate cause of death: Thrombosis, Cerebral	4 Mos.
Due to: Arteriosclerosis, Generalized	3 Yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. France Cook (MC) USNR
M. D. or other
Address: USN Hospital, Annapolis, Md. Date signed: 3-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

02498 P

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Brooklyn Park 25
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hammonds Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Dora Ciszewski — **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	married

6.(b) Name of husband or wife: Frank Ciszewski
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): November 6 1887

8. AGE: Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Henry Cemiak
13. Birthplace: Poland

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: Frank Ciszewski
Address: Hammonds Lane, Brooklyn Pk. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-26-45 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Brooklyn A.A. Co.

16. Funeral director: George A Weber
Address: 705 S Ann street

19. 3/23 19 45 C.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 19 45 at about 8 A M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Post Mortem Examination and that I last saw h... alive on March 21 19 45

Immediate cause of death	DURATION
Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident
Accident, suicide, or homicide: Date of 3/21/45
Where did injury occur? Brooklyn Park (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: fell into well Injured at work? No

23. SIGNATURE: John M. Claffy Deputy Medical Examiner M. D. or other
Address: Annapolis Md Date signed: 3/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Kee · d, U. S.
3/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (84-2)

CERTIFICATE OF DEATH

02499

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1908 Lauretta Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: -------

3. (a) FULL NAME: CLARK - GLADYS

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Sumner Clark, Jr.

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1919

8. AGE: Years: 26 | Months: unknown | Days: | If less than one day: --- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -------

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/31/45 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Balto Md
18. Funeral director: Mrs Geo F Holland
Address: 1631 Druid Hill Ave

19. March 27 1945 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1945, at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1945, to March 27 1945
and that I last saw her alive on March 27 1945

Immediate cause of death	DURATION
Exhaustion Delirium	Since 3/21/45
Due to: -------	
Due to: -------	
Other conditions: Schizophrenic	Since
Excitement and Exhaustion	3/21/45

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.: -------
Autopsy results: -------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: -------
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: ------- Injured at work? -------

23. SIGNATURE: Herbert Brinkwood M. D. or other
Address: Crownsville, Maryland Date signed: 3/27/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93-d)

Registered No. 21

02500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Anne Arundel Co.
(a) ~~Baltimore City~~, Maryland
(b) Street address Chesapeake Terrace
(c) Hospital or institution: Jones Creek - Md
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Jones Creek, Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice V. Cook

3 (b) If veteran, name war none.

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Benjamin Cook

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12 1864

8. AGE: Years 80. Months 2 Days 18. If less than one day hr. min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name James Brown
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ruth Cohon
15. Birthplace Gunpowder, Md

16 (a) Informant Benjamin Cook
(b) Address Jones Creek, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Schwartz Cem
Location O'Donnell St Road

18 (a) Funeral director Wendell J. Hippel
(b) Address 312 S. Highland Ave

19 (a) 3/9/45 (Date rec'd by registrar) (b) H. V. Hedrick D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 2:45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to March 6 1945, and that I last saw her alive on March 5 1945.

Immediate cause of death	Duration
Arteriosclerotic Heart Dis	20 years
Chr. Congestive Heart Failure	6 mos.
Due to	
Due to	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. R. Linder, M.D. M. D.

Address 520 D St. Sp Pt 19 Date signed 3.6.45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline **that particular ONE** cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

(M) P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

02501

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Patapsco Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Over 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland. County A. A.

City or town Patapsco Park. (If outside city or town limits, write RURAL and give nearest town)

Street No. Shenandoah & [illegible] Av. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Crowley

3. (b) Social Security Number

4. Sex F.

5. Color or race B.

6.(a) Single, married, widowed, or divorced Widow.

6.(b) Name of husband ~~or wife~~ John Crowley

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) ? ? 1902

8. AGE: Years 42? Months Days If less than one day ... hrs. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Housekeeping.

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden name ?

15. Birthplace ?

16. Informant Annie Royster (friend)

Address Patapsco Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2, 1945 (month) (day) (year)

Cemetery or crematory Mt Calvary Cemetery

Location A. A. County Md.

18. Funeral director Mrs. Robert A. Elliott & Dgt

Address 1129 N. Caroline St.

19. 4/2 (Date rec'd by registrar) 1945 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death Coronary Occlusion — DURATION sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

SIGNATURE Gustave H. Pouleur, MD. Medical Examiner M. D. or other

Address Glen Burnie Md. Date signed 3/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

02502

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 5

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: St Margarets

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Patricia Ann Dayhoff

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 18th 1945

8. AGE: Years — | Months — | Days | If less than one day ..... hrs. 35 min.

9. Birthplace: Annapolis Md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Edward Dayhoff

FATHER — 13. Birthplace: Cella Md.

MOTHER — 14. Maiden name: Priscilla Frey

MOTHER — 15. Birthplace: Cella Md.

16. Informant: Priscilla Dayhoff

Address: Cella Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 21st 1945 (month) (day) (year)

Cemetery or crematory: Private Cemetery

Location: Annapolis Neck

18. Funeral director: John M. Sayler

Address: Annapolis Md.

19. March 21 1945 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1945, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1945 to March 18 1945 and that I last saw h[illegible] alive on March 18 1945

Immediate cause of death	DURATION
Pneumonia	
Due to: About 5 to 5½ mos.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other

Address: Annapolis Md. Date signed: 3/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02503

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore Co.
City or town: Pikesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs.
Hospital, institution, or street address where death occurred: Emergency Hospital Towson
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto Co.
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: William H. Brown

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 29, 1885

8. AGE: Years 59 | Months 6 | Days 25 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore City (Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER
12. Name: William Wallace Brown
13. Birthplace: Balto Md.

MOTHER
14. Maiden name: Hester Bradley
15. Birthplace: Deale Island Md

16. Informant: Charles B. Burns
Address: Churchville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 25 1945 (month) (day) (year)
Cemetery or crematory: Deale Cem
Location: Deale Anne Arundel Co. Md

18. Funeral director: W. A. Sandosky & Son
Address: Galesville Md.

19. Mar. 25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24, 1945, at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1945, to March 24, 1945, and that I last saw h... alive on March 24, 1945.

	DURATION
Immediate cause of death: Bronchopneumonia	2 Days
Due to (Causal or Antecedent): Influenza	
Due to: not established	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Albert L. Frederson M.D. M. D. or other
Address: Annapolis, Md. Date signed: 3/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

02504

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: A. A. Co. Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: South River (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary L. Everett

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	~~Married~~ Widow

6.(b) Name of husband or wife: Edward Everett
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 19th 1857

8. AGE: Years: 87 | Months: 7 | Days: 19 | If less than one day: ..... hrs. ..... min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Charles Duvall
13. Birthplace: A A Co Md

MOTHER
14. Maiden name: Sarah Truppell
15. Birthplace: A A Co Md

16. Informant: Record of A A Co Home
Address: South River A A Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 13th 1945 (month) (day) (year)
Cemetery or crematory: Hope Chapel
Location: Mayo A A Co Md

18. Funeral director: John M. Lay Co
Address: Annapolis Md

19. Mar. 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1945 at 12 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3 1945 to March 11 1945 and that I last saw h[illegible] alive on March 9 1945

Immediate cause of death	DURATION
Chr. Myocarditis	Yrs.
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. F. Klemmans, M.D. M. D. or other
Address: 31 Southgate Ave Date signed 3/12/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

02505

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Anne Arundle (1860) Registration Dist. No. 190 23

Village or City Harmans No. St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Eliza Fairbanks If U. S. Veteran, specify WAR

(a) Residence: No. 1945 Railroad ave St. Ward.

(Usual place of abode) Elkridge Md. If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Fairbanks

6. DATE OF BIRTH (month, day, and year) Aug 23, 1846

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	98	7	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Housewife

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Anne Arundle (State or country) Md.

FATHER

13. NAME Isaiah Watts

14. BIRTHPLACE (city or town) Anne Arundle (State or country) Md.

MOTHER

15. MAIDEN NAME Ruth Arnold

16. BIRTHPLACE (city or town) Anne Arundle (State or country) Md.

17. INFORMANT William S. Horsey

(Address) 1945 Railroad ave Elkridge Md.

18. BURIAL, CREMATION, OR REMOVAL

Melvill Cemetery Place Elkridge Md. Date March 29, 1945

19. UNDERTAKER S. Lester Earp

(Address) 5543 Main St. Elkridge Md.

20. FILED March 28, 1945 Miss E. Rita Williams Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March 27- 45 (Month) (Day) (Year), 193

22. I HEREBY CERTIFY, That I attended deceased from March 25-45, 19 to March 27-45, 19

I last saw h— alive on March 25-45, 19; death is said to have occurred on the date stated above, at 11A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Shock from face.	

Other Contributory Causes of importance: Right fracture of ~~left~~ arm + fracture ~~left~~ Right hip Badly

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? —

23. If death was due to external causes (VIOLENCE) fill in also the following: March 25-45

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? Harmans Md. (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. Home

Manner of injury Fall on steps

Nature of injury Fracture Right arm + Right hip

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J. M. Lapsley M. D.

(Address) Elkridge Md

March 28-45

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

02506

CERTIFICATE OF DEATH

Reg. Diat. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessups, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 days

Hospital, Institution, or street address where death occurred:
MARYLAND HOUSE OF CORRECTION

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Cordova, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME
WILLIAM FOREMAN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Married

6.(b) Name of husband or wife: Mildred Foreman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4, 1911

8. AGE: Years	Months	Days	If less than one day
33	7	24	..... hrs. ..... min.

9. Birthplace: Centerville, Maryland
(Town, county, and state)

10. Usual occupation: Farm laborer

11. Industry or business

FATHER
12. Name: Not known
13. Birthplace " "

MOTHER
14. ~~Maiden~~ Name: Rosie Foreman
15. Birthplace: Easton, Maryland

16. Informant: MARYLAND HOUSE OF CORRECTION
Address: Jessups, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 12 1945 (month) (day) (year)

Cemetery or crematory: Cemetery
Location: Cordova

18. Funeral director: John P. Williams
Address: Easton Md

19. Mar 18 1945 (Date rec'd by registrar) Clara Easley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8, 1945 19..... at 1:30P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 28 1945 to March 8 1945 and that I last saw him alive on March 8 1945

Immediate cause of death	DURATION
Uraemia	
Due to: Diabetic coma	12 hrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John A Clark
John A. Clark, M.D. M. D. or other

Address: Jessups, Maryland Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93-1

Registered No. 25

02507

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4801 Wasena

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County D.C.Co

(c) City or town Baltimore Brooklyn
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4801 Wasena Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E. Gischel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm G. Gischel

6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) 3/11/82

8. AGE: Years	Months	Days	If less than one day
63	0	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name Unknown - Bradley

13. Birthplace Maryland

MOTHER

14. Maiden Name Sarah Bradley

15. Birthplace Maryland.

16 (a) Informant Mrs Emma K. Budahazy

(b) Address 4801 Wasena Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/45 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Blvd.

18 (a) Funeral director John F Henny Inc

(b) Address 718 Light St.

19 (a) 3/24/45 (Date rec'd by registrar) (b) Alv. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/45 19 , at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940, to 3/21 1945.

and that I last saw her alive on 3/15 1945.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertension	11 yrs.
Due to	
Other Conditions My poor dear died Instantly	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Lee D. Herbert M. D.

Address 4710 Pennington Date signed 3/24/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

02508

CERTIFICATE OF DEATH

Reg. Diat. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport (If outside city or town limits, write RURAL and give nearest town)
Street No. 600 Parkwood Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Dallas Morgan Grady, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1927

8. AGE: Years	Months	Days	If less than one day
17	11	17	hrs. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Dallas M. Grady, Sr.
13. Birthplace Washington, D.C.

MOTHER
14. Maiden name Lucile M. Anderson
15. Birthplace Winchester, Va.

16. Informant Dallas M. Grady, Sr.
Address 600 Parkwood, Eastport Md.

17. Burial Date thereof March 26 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Mary's
Location Annapolis, Md.

18. Funeral director John M. Taylor
Address Annapolis Md.

19. Mar. 26 19 45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 5.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 1945, to March 22 1945
and that I last saw him alive on March 22 1945

Immediate cause of death	DURATION
Cardio Vascular Collapse	Instantaneous
Due to Tuberculosis of Both Kidneys & Bladder	About 1/2 Year
Due to	Several Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Holmes Purvis M. D. or other
Address Annapolis Md. Date signed March 24/45

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

02509

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1207 West St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Margaret R. Graefe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George E. Graefe
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28th 1887

8. AGE: Years	Months	Days	If less than one day
57	9	25	hrs. min.

9. Birthplace: Baltimore Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: George E. Keelholtz
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Margaret E. Bowen
15. Birthplace: Richmond Va

16. Informant: George E. Graefe
Address: 1207 West St. Annapolis Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Mch 26th 1945
(month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md
18. Funeral director: John M. Taylor
Address: Annapolis Md

19. Mar 26 1945
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 1945, at 9:38 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1945, to March 23 1945
and that I last saw h[illegible] alive on March 23 1945

Immediate cause of death	DURATION
Coronary Thrombosis	4½ Days
Due to: Hypertension & Arterial Hypertension	Several yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Oliver Furnis M. D. or other
Address: Annapolis Md Date signed: 3/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age & year of birth of deceased is shown on FILM G 97 AUG 31 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95d)

CERTIFICATE OF DEATH

02510

Reg. Dist. No. 27

1. PLACE OF DEATH:

County Ann Arundel

City or town Skidmore (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newboro infants give residence of mother)

State Md. County A.A.

City or town Skidmore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ANNIE MARIAH HARRIS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife Alfred Harris 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, ~~1864~~ 1874

8. AGE: Years	Months	Days	If less than one day
71- 70	5 6	27	hrs. min.

9. Birthplace A. A. Co. Md. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name John Washington

13. Birthplace Md.

MOTHER 14. Maiden name Annie Washington

15. Birthplace Md.

16. Informant William H. Barnes

Address 534 E Gordon St. Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 18, 1945 (mooth) (day) (year)

Cemetery or crematory Broad Neck

Location Skidmore Md.

18. Funeral director L.B. Johnson

Address Annapolis Md.

19. March 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1945 at 4 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1945, to March 14 1945 and that I last saw h.r alive on March 7 1945

Immediate cause of death	DURATION
Chr Myocarditis	
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. F. Kleaveland Md M. D. or other

Address 31 South St Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02511

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 5 days

Hospital, institution, or street address where death occurred: Annapolis State Hospital

How long in hospital or institution? 2 months 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 West 22 Street

(If rural, give LOCATION)

2.(a) If veteran, name war: — — —

3.(a) FULL NAME Edna Harris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widowed.

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1912

8. AGE: Years	Months	Days	If less than one day
32	unknown		hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: — —

FATHER 12. Name: John Fuller

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Fanny Johnson

MOTHER 15. Birthplace: Virginia

18. Informant: Hospital Records

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 14 1945 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cem

Location: Annapolis Rodd.

18. Funeral director: Mrs Robert Elliott daughter

Address: 1189 n. Carolina St.

19. 3/13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10, 1945 at 8 50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 5 1945, to March 10 1945

and that I last saw h.. alive on March 10, 1945

Immediate cause of death	DURATION
General Paresis	
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

02514

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel.
City or town: Severna Park.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cypress Creek.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Charles Howard Hosey Sr.

3.(b) Social Security Number: No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed.

6.(b) Name of husband or wife: Elizabeth DORSCHKY

6.(c) If alive, give age: dead. years

7. Birth date of deceased (mo., day, yr.): February-11-1865

8. AGE: Years: 80 | Months: 0 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Towson, Maryland (Town, county, and state)

10. Usual occupation: Police officer (Retired)

11. Industry or business

FATHER
12. Name: Jacob Hosey
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Martha Ann Jones
15. Birthplace: Richmond, Va

16. Informant: Mrs. Jones Hosey
Address: 704 - East 28th street, Baltimore.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/10/45 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto Co.

18. Funeral director: C. J. Tammany & Son
Address: 1938 E. Lafayette Ave.

19. 3/8/45 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 1945, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 1944 to 3/7/45 19..
and that I last saw him alive on 3/7/45 19..

Immediate cause of death	DURATION
Heart failure	
Due to: Generalized arteriosclerosis	5 yrs.
Due to: Senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Parker Dist. M. D. or other
Address: Glen Burnie Md. Date signed 3/7/45

Rec'd. U.S.
3/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

02512

Reg. Dist. No. 27

1. PLACE OF DEATH:

County Anne Arundel

City or town Ft. George G. Meade

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

–

How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Oregon County –

City or town Manning

(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 9

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edward C. HAYES, 2d Lt O-1,014,703

3. (b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife –

6.(c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) June 14, 1923

8. AGE:

Years	Months	Days	If less than one day
21	9	15	... hrs. ... min.

9. Birthplace Unknown

(Town, county, and state)

10. Usual occupation Officer

11. Industry or business U. S. Army

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Madie (unknown) Hayes

15. Birthplace

16. Informant WD AGO Form 61 Officers Qualification Card

Address U. S. Army

17. Removal Date thereof 29 Mar 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Undertaking Co

Location Forest Grove, Oregon

18. Funeral director Howard Blight Jr

Address 4914 Belair Road, Baltimore, Md.

19. 29 March 1945 W J Lawson Jr

(Date rec'd by registrar) W J LAWSON JR 1st Lt MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..; that I last saw deceased on ... 19..; that I viewed ... 19 45

Immediate cause of death	DURATION
Wounds, multiple, involving almost complete anatomical derangement of body, caused by accidental explosion of bangalore torpedo with instantaneous death.	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations –

Date of op. –

Autopsy results Not performed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 28 Mar 45

Where did injury occur? Ft Meade (City or town) Anne Arundel (County) Md (State)

Injured at home, farm, industry, public place (where?) Firing Range

Means of injury Bangalore torpedo Injured at work? Yes

23. SIGNATURE John J Corcoran Capt MC

M.D. or other

Address Rec Hosp Ft Meade Md Date signed 29 Mar 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02513 8

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1303 North Stricker Street (If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: HENSON - DELLA

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1871 (?)

8. AGE: Years	Months	Days	If less than one day
74	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ---

FATHER 12. Name: Benedict Cole

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Caroline Brown

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: March 24, 1945 (month) (day) (year)

Cemetery or crematory: Asbury Cemetery

Location: Harford County, Maryland

18. Funeral director: Mrs. Frances Hemsley

Address: 578 W. Biddle St., Balto., Md.

19. 3/21/45 (Date rec'd by registrar) E. Joyce Rose Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1939 to March 20 1945 and that I last saw h[er] March 20 1945 alive on

Immediate cause of death	DURATION
General Arteriosclerosis -	About 6
Chronic Myocarditis	months
Due to: ----- ------	
Due to: ----------	
Diher conditions: Senile Psychosis -	Known to u Since
Simple Deterioration	3/20/39

(Include pregnancy within 3 months of death)

Major findings of operation: ---------- Date of op.: ------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --------- Date of: ------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ---------- Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 3/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

02515

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: A. A. Co.
~~City or~~ town: Annapolis Junction
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Rural
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A. Co.
City or town: Annapolis Junction
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Louis Hueg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Sophia Hueg
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 17th 1871

8. AGE: Years	Months	Days	If less than one day
73	3	13	hrs. min.

9. Birthplace: Hanover Germany
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Cabinet Maker
FATHER 12. Name: Frederick Hueg
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: William A. Hueg
Address: Annapolis Jct. Md.
17. (Burial, ~~cremation, or removal~~. Which?) Burial Date thereof 4/2/45 (month) (day) (year)
Cemetery or ~~crematory~~: Glen Haven
Location: Glen Burnie A. A. Co. Md.
18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.
19. 4/2 19 45 (Date rec'd by registrar) A W Frederick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3. 30 1945, at 8 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935, to 3 30 1945
and that I last saw him alive on 3 30 1945

	DURATION
Immediate cause of death: Heart Block	
Cerebral Thrombosis	1 3 yrs.
Due to: Chr. Nephritis	
Due to: Hypertrophied Prostate	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B P Warren M. D. or other
Address: Laurel Md. Date signed 3-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-B)

CERTIFICATE OF DEATH

02516

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Rhode River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Edgewater Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME Roland Thomas Ireland
3.(b) Social Security Number 214-05-0419

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Ruth S. Ireland
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Jan 25, ~~18~~ 1897

8. AGE: Years 48 Months 1 Days 26 If less than one day ... hrs. ... min.
9. Birthplace South River Md
(Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business Boat Building
FATHER 12. Name Thomas H. Ireland
13. Birthplace Calvert Co
MOTHER 14. Maiden name Sarah V. Asquith
15. Birthplace South River
16. Informant Ruth S. Ireland
Address Edgewater
17. Burial Date thereof April 2 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hope Chapel
Location South River
18. Funeral director G. A. Sandrof & Son
Address Galesville
19. April 2 1945 Edward Callenan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1945, at ? M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend 19..., to ... 19...
and that I last saw h... alive on ... 19...
Immediate cause of death Drowning-Suicidal — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 3/21/45
Where did injury occur? AA Co Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Rhode River
Means of injury
Injured at work?

23. SIGNATURE F. B. Hest Dep. Med. Exam. M. D. or other
Address Date signed

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

02517

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs., 6 mos., 8 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 13 yrs., 6 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ------ ✓

3. (a) FULL NAME: JANIFER - ELIZABETH

3. (b) Social Security Number: ---------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ---------
6.(c) If alive, give age ---- years
7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years	Months	Days	If less than one day
70	unknown	----	---- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: ------

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof March 23 1945 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location: Westport, Baltimore

18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St. Balto., Md.

19. 3/21 45 (Date rec'd by registrar) E Hope Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 19 45 at 4:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11 19 31 to March 19 19 45 and that I last saw her alive on March 19 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	About 3 mos.
Due to: ---------	
Due to: ---------	
Other conditions: Feebleminded without Psychosis	Known to us since 9/11/31

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.: ------
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: ------
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: ------ Injured at work? -----

23. SIGNATURE: Joel D. Hunteman M. D. or other
Address: Crownsville, Maryland Date signed: 3/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

02518 Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred: crownsville State Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 588 Prestman Street
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME Sylvanious Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1922.

8. AGE: Years	Months	Days	If less than one day
22			..... hrs. ..... min.

9. Birthplace: N. C. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business
FATHER 12. Name: mark Johnson
13. Birthplace
MOTHER 14. Maiden name: Carrie Smith
15. Birthplace
16. Informant: Hospital records
Address: crofonsville, md.
17. Ship (Burial, cremation, or removal. Which?) Date thereof 3/13/45 (month) (day) (year)
Cemetery or crematory
Location: Hailfax N.C.
18. Funeral director: Raymon Sanders
Address: 1412 E. Preston Street
19. 3/[illegible]/45 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10-45 19 45, at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-2 19 45 to 3-10 19 45
and that I last saw him alive on 3-10 19 45
Immediate cause of death: Pneumonia — DURATION: 2 days
reported Broncho
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Herbert Whitehead M. D. or other
Address: Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18, Md.

CERTIFICATE OF DEATH

02519

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Marley Neck road

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Marley Neck road

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME GEORGE WASHINGTON KESS

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife Irene Kess

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1884

8. AGE: Years	Months	Days	If less than one day
61	-	15	hrs. min.

9. Birthplace Marley, A. A. Co., Md. (Town, county, and state)

10. Usual occupation farmer

11. Industry or business

FATHER 12. Name Roderick Kess

13. Birthplace A. A. Co., Md.

MOTHER 14. Maiden name Henrietta Spencer

15. Birthplace A. A. Co., Md.

16. Informant Irene Kess

Address Marley Neck, P. O. Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-12-45 (month) (day) (year)

Cemetery or crematory Mt. Calvary Cemetery

Location A. A. Co., Md.

18. Funeral director Kate Williams

Address Schroeder st., Balto., Md.

19. 3-8 19 45 L. A. Brit (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 19 45 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 7 19 40 to Mar. 8 19 45

and that I last saw him alive on March 6 19 45

Immediate cause of death	DURATION
Congestive heart failure	4 mos.
Due to Arteriosclerotic heart disease ?	
Due to	
Other conditions Arthritis deformans	9 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. A. Brit, M. D.

M. D. or other

Address Pasadena, Md. Date signed 3-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

02520 23

Reg. Dist. No. .....

P

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County a. a.

City or town Linthicum (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County a. a.

City or town Linthicum (If outside city or town limits, write RURAL and give nearest town)

Street No. Camp Meade Rd. (If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME William Otto Edward Koch

3. (b) Social Security Number 215-05-8721

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Lillian B. Koch 6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Nov. 16 - 1887

8. AGE:

Years	Months	Days	If less than one day
57	4	3	..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Dentist

11. Industry or business Commercial

FATHER 12. Name Wm Koch

13. Birthplace Germany

MOTHER 14. Maiden name Mary Zilker

15. Birthplace Baltimore

16. Informant Mrs. Lillian B. Koch

Address Linthicum, Md.

17. Burial - (Burial, cremation, or removal, Which?) Date thereof March 22 45 (month) (day) (year)

Cemetery or crematory Loudon Park

Location 3801 Frederick Ave

18. Funeral director John O. Mitchell & Son

Address 1900 Eutaw Place

19. 3/20 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945 at 1:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1945, to March 19 1945 and that I last saw h alive on March 19 1945

Immediate cause of death / Cardio-Vascular Disease (Had acute attack 4 mo. ago)

DURATION: 5-6 yrs.

Due to .....

Due to .....

Other conditions Arteriosclerosis 5-6 yrs.
+ Hypertension -

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas. L. Bace, Jr. M.D. M.D. or other

Address Linthicum Date signed 3-19-45

1944
62
82

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

02521

Reg. Diat. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Ann arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 73 Clay St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Matilda Elizabeth Larkins.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Felale	Colored	Widow

6.(b) Name of husband or wife: Joseph Larkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 17, 1858

8. AGE: Years	Months	Days	If less than one day
87		30	..... hrs. ..... min.

9. Birthplace: A.A. CO. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER

12. Name: Minor Walker

13. Birthplace: A.A.CO.

MOTHER

14. Maiden name: Elizabeth Harriet

15. Birthplace: A.A.CO.

16. Informant: George L. Larkins

Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 20, 1945 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis

18. Funeral director: J.B. Johnson

Address: Annapolis Md.

19. March 20 19 45 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16, 1945 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/15 1945, to 3/16 1945

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiac Failure	5 dys.
Due to: Hypertension & Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Theodore H. Johnson M.D. M. D. or other

Address: 35 Northwest Street Date signed 3/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02522

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3-8-17

Hospital, institution, or street address where death occurred:
52 Maiden Ln

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 52 Maiden Ln
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Gary Robert League

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 30 — 1941

8. AGE:	Years	Months	Days	If less than one day
	3	8	17	....hrs. ....min.

9. Birthplace: Annapolis Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: John O. League

FATHER — 13. Birthplace: West Annapolis Md

MOTHER — 14. Maiden name: Nancy E. Mitchell

MOTHER — 15. Birthplace: Baltimore Md

16. Informant: Caroline E. Mitchell
Address: 52 Maiden Ln Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 21/45 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md

18. Funeral director: B. L. Hopkins

Address: Annapolis Md

19. March 20 19 45 (Date rec'd by registrar) T. Mush Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 19 45 at 5 15 P M

21. I CERTIFY that death occurred on the date above stated; [redacted]
Post mortem Examination
[redacted] March 17 19 45

Immediate cause of death	DURATION
Fracture of Skull	Sudden
Due to (Traffic accident)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 3/17/45
Where did injury occur? [redacted] Annapolis (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) near Corp Melson & Hill Sts
Means of injury: automobile Injured at work? no

23. SIGNATURE: John M. Caffe Deputy Medical Examiner M. D.
Address: Annapolis Md Date signed: 3/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02523 Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Dorsey mp
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Dorsey md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County:
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.: Dorsey. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah LEE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Woman.	Colored	Widowed

6.(b) Name of husband or wife: John H LEE
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March. 20 1861

8. AGE: Years: 84 Months: Days: If less than one day: hrs. min.

9. Birthplace: Dorsey md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Unknown.
13. Birthplace: Unknown

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: Lucile Cook
Address: Dorsey md

17. (Burial, cremation, or removal. Which?) Date thereof: 4-2-1940 (month) (day) (year)
Cemetery or crematory: St. Rest Cem 4 2 1940
Location: A A Co Md

18. Funeral director: Mrs Katie K Williams
Address: 322. W. Lafayette Ave
Mar 31 1945 (Date rec'd by registrar) Elsie Hosfeld Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1945, at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1945 to Mar. 30 1945 and that I last saw her alive on Mar. 29 1945

Immediate cause of death	DURATION
Cerebral Haemorrhage	5 days
Due to: Hypertension.	10 yrs.
Due to: arteris-sclerosis.	10 yrs.
Other conditions: Chr. Myocarditis -	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op.:
Autopsy results: ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Shipley, M.D. M. D. or other
Address: Savage, Md. Date signed: 3/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

CERTIFICATE OF DEATH

02524

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 932 Frances
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Susan Alethia Lee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Alexander W. Lee
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5th 1865

8. AGE:

Years	Months	Days	If less than one day
79	9	24	hrs. min.

9. Birthplace Shadyside A A Co Md
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name John Smith
13. Birthplace A A Co Md.
MOTHER 14. Maiden name Sallie Ruby
15. Birthplace Green Ann Co Md.
16. Informant Father A. Lee
Address 932 Frances St Eastport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 4th 1945 (month) (day) (year)
Cemetery or crematory Woodfield
Location Galesville Md.
18. Funeral director John M. Taylor
Address Annapolis Md.
19. Mar. 4, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st 1945, at 12:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26th 1945 to March 1st 1945
and that I last saw h[illegible] alive on March 1st 1945

	DURATION
Immediate cause of death Heart attack	5 days
Due to Angina pectoris	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. T. Russell M. D. or other
Address Eastport, Md Date signed 3-3-45

(M)
(1)
MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

02525

B3-a

1. PLACE OF DEATH

County A. A. Co. Registration Dist. No. 21

Village or City Rock View Bch. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

2. FULL NAME Amanda G. Linderborn (Linderborn)

(a) Residence: No. Rock View Beach St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W.	M

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Phillip R.

6. DATE OF BIRTH (month, day, end yaar) Ap. 30, 1866

7. AGE	Yaars	Months	Deys	If LESS than 1 day, hrs. or min.
	78	0	25	

OCCUPATION

8. Trada, profession, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date dacaasad last workad at this occupetion (month and year)

11. Total tima (yaers) spant in this occupation

12. BIRTHPLACE (city or town) Pa.
(State or country)

FATHER

13. NAME Christian Smith

14. BIRTHPLACE (city or town) Pa
(State or country)

MOTHER

15. MAIDEN NAME ?

16. BIRTHPLACE (city or town) Pa.
(Stete or country)

17. INFORMANT Family
(Address) Rock View Beach.

18. BURIAL, CREMATION, OR REMOVAL
Place ~~Holl~~ Date 3/28, 1945

19. UNDERTAKER James L. McCauley
(Address) 130 E. Fort Ave.

20. FILED 3/28, 1945 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March 25, 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1945, to March 31, 1945

I last saw her alive on March 25, 1945; death is said to have occurred on the date stated above, at 5:20 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	10 days
Hypertension	Many years
Myocardial Insufficiency	3 days

Other Contributory Causes of importance:

Name of operetion Date of

What tast confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Whara did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Neture of injury

24. Was disease or injury in any way relatad to occupation of deceased?

If so, specify

(Signad) Leon Poltarsky M. D.

(Addrass) 4700 Pennsylvania Ave. Balto 26 Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

02526 P

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

336 Broadview Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Same County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lewis McClain

3.(b) Social Security Number 214-01-3035

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Sophia McClain

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 1 1881

8. AGE: Years 63 | Months 5 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Tool maker.

11. Industry or business Aircraft Co.

FATHER 12. Name John E. McClain

13. Birthplace Baltimore

MOTHER 14. Maiden name Annie Elliott.

15. Birthplace Baltimore, Md.

16. Informant Mr. Sophia McClain

Address Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/45 (month) (day) (year)

Cemetery or crematory Moreland Memorial Park

Location

18. Funeral director Clarence F. Hoffmann

Address 1639 N. Broadway

19. 3/27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1945, to March 25 1945 and that I last saw him alive on March 25 1945

	DURATION
Immediate cause of death Cardio-Vascular Disease	8 mo
Due to	
Due to	
Other conditions Arteriosclerosis.	8 yr

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr. M.D. M. D. or other

Address Linthicum Date signed 3-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

P

02527

1. PLACE OF DEATH (946)

County Anne Arundel Registration Dist. No.

Village or City Sally Ford No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Harry W. Brown

(a) Residence: No. Sally Ford St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M.	W	M.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah C. Trump.

6. DATE OF BIRTH (month, day, and year) Aug 22, 1886

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	6	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Painter

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. U.S.C.G.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Md.

FATHER

13. NAME Thomas W.

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Mary E. Anthony

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Family (Address) Sally, Md.

18. BURIAL, CREMATION OR REMOVAL Place Cedar Hill Date 3/20, 19 45

19. UNDERTAKER James L. McCully (Address) 1130 E. Fort Ave.

20. FILED 3/19, 19 45 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March 16, 1945 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July-10, 19 44, to March 16, 19 45

last saw him alive on March 16, 19 45; death is said to have occurred on the date stated above, at m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
— Angina Pectoris	8 mo.

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any wey related to occupation of deceased?

If so, specify

(Signed) C. B. Wheeler M. D.

(Address) 1279 William St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

02528

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A A
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 95½ West
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Baby Moreland

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11th 1945

8. AGE: Years	Months	Days	If less than one day
—	—		hrs. few min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name James W. Moreland
13. Birthplace A A Co Md

MOTHER
14. Maiden name Marie G. Starlings
15. Birthplace A A Co Md

16. Informant James W. Moreland
Address 95½ West St. Annapolis Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Mar 12-1945 (month) (day) (year)
Cemetery or crematory Mt. Zion
Location Mt. Zion A A Co Md

18. Funeral director John M. Taylor
Address Annapolis Md.

19. Mar. 11, 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11th 1945, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 , to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Prematurity 5½	
Due to Weakness Developed	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

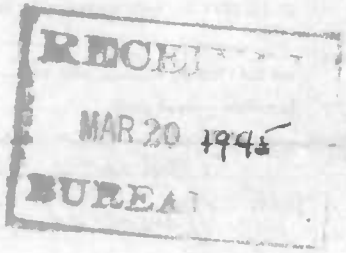
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Oliver Purnell M. D. or other
Address Annapolis Md Date signed 3/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

02529

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Mryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 14 West 4th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3. (a) FULL NAME: NAYLOR - JOHN HENRY

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: --------

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): November 10, 1885

8. AGE: Years	Months	Days	If less than one day
59	4	5	--- hrs. --- min.

9. Birthplace: Frederick, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown
FATHER 12. Name: Henry Naylor
FATHER 13. Birthplace: Frederick County, Md.
MOTHER 14. Maidee name: Charlotte Weedon
MOTHER 15. Birthplace: Frederick County, Md.
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Buried (Burial, cremation, or removal. Which?) Date thereof March 19, 1945 (month) (day) (year)
Cemetery or crematory: Della
Location: Frederick County, Maryland
18. Funeral director: M. R. Etchison
Address: Frederick, Maryland
19. 3/15 1945 (Date rec'd by registrar) E. R. Joyce, Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15, 1945, at 8:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1945 to March 15 1945 and that I last saw him alive on March 15 1945

Immediate cause of death	DURATION
Gangrene of Both Hands	Known to us since 3/7/45
Due to: General Arteriosclerosis	Prior to admission
Due to: ---------	
Other conditions: Delirious Reaction	Prior to admission

(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op.: ------
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of: --------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public places (where?): --------
Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Hal J. Hinkowski M. D. or other
Address: Crownsville, Maryland Date signed: 3/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

02530

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: A. A.
City or town: Best Gate
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Best Gate
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Imand Peters

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	colored	married

6.(b) Name of husband or wife: Daniel Peters
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years	Months	Days	If less than one day
49			hrs. min.

9. Birthplace: Edmore
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: Arthur Green
13. Birthplace: Md.
MOTHER 14. Maiden name: Rachel Hutzman
15. Birthplace: Arnold.
16. Informant: Daniel Peters
Address: Best. Gate.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 6 1945 (month) (day) (year)
Cemetery or crematory: Broadneck
Location: St Margrets.
18. Funeral director: J. B. Johnson
Address: Annapolis
19. Mar. 3 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 1 1945 at 11 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem Examination, 19..., and that I last saw ... alive on Mar. 1 1945.

Immediate cause of death	DURATION
Coronary embolus	Sudden
Due to: Coronary Sclerosis	unknown
Other conditions: La Grippe	1 week

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: John N. Coffy Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 3/1/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

02531 P

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Few minutes
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Brooklyn - 25
(If outside city or town limits, write RURAL and give nearest town)
Street No. Furnace Branch Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harrison S. Pye

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Separated Married

6.(b) Name of ~~husband or~~ wife Gertrude Pye
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 29th 1890

8. AGE: Years	Months	Days	If less than one day
54	7	13	..... hrs. ..... min.

9. Birthplace West Chester Pa
(Town, county, and state)
10. Usual occupation Owner
11. Industry or business Tavern
FATHER 12. Name Ernest Pye
13. Birthplace Ind
MOTHER 14. Maiden name Annie C. Safford
15. Birthplace Mass
16. Informant Gertrude Pye
Address Bristol Pa
17. Burial Date thereof 3/16/45
(Burial, ~~cremation, or removal. Which?~~) (month) (day) (year)
Cemetery ~~or crematory~~ Glen Haven
Location Glenburnie Md
18. Funeral director William Cook Inc.
Address 1217 St. Paul St
19. 3/15 45 Anne Arundel County
(Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945 at 10.35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Sudden death due to	
Coronary Occlusion	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Gustave H. Rauber MD
~~attending~~ medical ~~M. D. Address~~
Address Glen Burnie Md Date signed 3/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

NAME: Spring Grove letter filmed 2-5-46 G100 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

02532 P 28

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 19 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 167 Winters Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME RAVELING RAVLING - MELINDA (Rawlings)

3.(b) Social Security Number unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m female	black	married

6.(b) Name of husband or wife: Philipp Ravling
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1894 ?

8. AGE: Years	Months	Days	If less than one day
51 ?	unknown	---	--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ---

FATHER
12. Name: Edward Adams
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-9-45 (month) (day) (year)
Cemetery or crematory: Western Star
Location:

18. Funeral director: A. Halstead
Address: 918 DRuid Hill Ave.

19. 3/7/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 19 45 at 7:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16 19 44 to March 5 19 45 and that I last saw her alive on March 5 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	known to us since 12/16/44
Due to: ---	
Due to: ---	
Other conditions: Arteriosclerosis	known to us since 12/16/45
Diabetes Mellitus (Include pregnancy within 3 months of death)	

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ---
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Fred H. Winkelmann M. D. or other
Address: Crownsville, Maryland Date signed: 3/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-C)

02533

CERTIFICATE OF DEATH

Reg. Diat. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:
Regional Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N.C. County: Unknown

City or town: Asheville,
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 132 Shelburne Road
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: Alphonzo C. REYNOLDS

3.(b) Social Security Number: 0-1,327,577

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Louisa C. Reynolds

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): May 24, 1914

8. AGE: Years	Months	Days	If less than one day
30	9	25	... hrs. ... min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: W.D., A.G.O. Form 61, Officer's
Address: Qualification Card.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/21/45 (month) (day) (year)

Cemetery or crematory: Morris Gearing Funeral Home

Location: 140 Merriman Ave., Asheville, N.C.

18. Funeral director: Howard H. Blifft Jr.

Address: 4914 Belair Road.

19. 21 March 19 45 (Date rec'd by registrar) W.J.LAWSON JR. 1st Lt. MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 March 19 45, at 6:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Mar 19 45, to 20 Mar 19 45, and that I last saw him alive on 20 Mar 19 45

Immediate cause of death	DURATION
Laceration Lbrain - severe	6 hrs
Hemorrhage - severe -	3 hrs
Due to Penetrating wound of head	3 hrs.
Gunshot wound, Caliber 45, right parietal	
Due to region of skull. C.W.&R.	
Suicide.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

~~Accident~~, suicide, ~~homicide~~? * Date of 20 March 45

Where did injury occur? Ft. Geo Meade (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?) *

Means of injury Gunshot wound. Injured at work? *

23. SIGNATURE: vt Mansfield - Maj. M. D. or other

Address: Reg. Hosp, Ft. Meade, Md. Date signed: 21 Mar 45

* Pending investigation

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02534 P

Reg. Dist. No. 21

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Riviera Beach (Pasadena Post Office)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years 8 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Riviera Beach – Pasadena Post Office

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main and Aubrey Roads

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Jacob Shotwell Robeson

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

8.(b) Name of husband or wife: Harriett Richards Robeson

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Sept. 19–1865

8. AGE:

Years	Months	Days	If less than one day
79	6	—	....hrs. ....min.

9. Birthplace: Rahway – New Jersey

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Daniel Stroud Robeson

13. Birthplace: Belvedere – New Jersey.

MOTHER

14. Maiden name: Jane Caroline Martin

15. Birthplace: Rahway New Jersey.

16. Informant: Harriett R. Robeson

Address: Main & Aubrey Rds. – Riviera Beach – Pasadena P.O.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/22/45 (month) (day) (year)

Cemetery or crematory: Green Mount

Location: Baltimore Md

18. Funeral director: Wilson & Son Inc

Address: 1317 Eutaw St

19. 3/20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 – 1945 at 4.45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 20 – 1944 to March 18 – 1945

and that I last saw h... alive on March 18 1945

Immediate cause of death	DURATION
Organic Heart Disease	unknown
Due to	
Due to	
Other conditions: Fractured – discounted left femur.	8 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chester Riland, M.D.

M. D. or other

Address: Asburies & Park Rds Riviera Beach Date signed 3-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02535

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 49 College Creek Terrace.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Emma Susan Ross

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: John Ross

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 25, 1883

8. AGE: Years	Months	Days	If less than one day
61	7	2	hrs. min.

9. Birthplace: A. A. Co.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: ~~Unknown~~ John Thomas

13. Birthplace: A.A.Co., Md.

MOTHER — 14. Maiden name: Rachiel Thomas

15. Birthplace: A. A. Co.

16. Informant: Carry Mc Gowan

Address: 49 College Creek Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 31, 1945 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis, Md.

18. Funeral director: J.B. Johnson.

Address: Annapolis, Md.

19. Mar. 31 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27, 1945, at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15 1927, to March 27 1945; and that I last saw her alive on March 27 1945

Immediate cause of death	DURATION
Carcinoma of Bronchial Gentic Carcinoma	3 Yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dr. Theodore F. Johnson M. D. or other

Address: 35 Northwest Street Date signed: 3/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

02536

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? four years

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? four years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore County

City or town Hereford
(If outside city or town limits, write RURAL and give nearest town)

Street No. Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war -------

3. (a) FULL NAME SMITH - ELLSWORTH

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 6, 1914

8. AGE: Years	Months	Days	If less than one day
30	11	25	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business ~~Balto Co, Md.~~

FATHER
12. Name George Smith
13. Birthplace Balto. Co., Md

MOTHER
14. Maiden name Amelia Gray
15. Birthplace --- Balto Co., Md.

16. Informant Hospital Records

Address Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Mar 6 1945 (month) (day) (year)

Cemetery or crematory St. Lukes

Location Millersville, Balto. Co., Md

18. Funeral director Lawson M. Bowles

Address Severna Park, Md

19. 3/3 1945 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945 at 10:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1940 to March 2 1945 and that I last saw her alive on March 2 1945

	DURATION
Immediate cause of death ..... Lung Tuberclosis	about five months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---- Date of op. .....

Autopsy results -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ------ Date of -----

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury --- Injured at work? ----

23. SIGNATURE Albert V. Ellsworth M. D. or other

Address Crownsville, Maryland Date signed 3/2/45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02537

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs, 7 mos, 18 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 5 yrs, 7 mos, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give resideoce of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL aod give nearest town)
Street No. 420 E. Pennsylvania Ave.
(If roral, give LOCATION)
2.(a) If veteran, name war: ----------

3. (a) FULL NAME: SMITH - VIOLA E.

3. (b) Social Security Number: ---------

4. Sex	5. Color or race	6.(a) Siogle, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ---------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1918

8. AGE: Years	Months	Days	If less than one day
27	unknown		---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: --------

FATHER — 12. Name: Rogers Smith
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Priscilla Watkins
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof Mar. 20, 1945 (month) (day) (year)

Cemetery or crematory: Pleasant Rest Cemetery
Location: Towson, Maryland

18. Funeral director: Byron & Mamie Wright
Address: 721 Aisquith St., Balto., Md.

19. 3/17 45 E. T. Joyce Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 19 45 at 3:00P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 28 19 39 to March 16 19 45 and that I last saw h...er alive on March 16 19 45

Immediate cause of death	DURATION
Lung Tuberculosis	since 8/14/44
Due to: ----------	
Due to: ----------	
Other conditions: Psychosis with Mental Deficiency (Include pregnaney within 3 months of death)	Known to us since 7/28/39

Major findings of operations: ---------
Date of op.: ---------
Autopsy results:
PHYSICIAN: Please underline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --------- Date of: ---------
Where did injury occur? ---------
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---------
Means of injury: --------- Injured at work? ---------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 3/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02538

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arrundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arrundel
City or town: Margate
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Box # 298, R. F. D. # 9
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: CATHERINE ELIZABETH SPIKER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward Thomas Spiker, Sr.
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): 11-27-1879

8. AGE: Years	Months	Days	If less than one day
65	3	6	...hrs. ...min.

9. Birthplace: Alleghaney County, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Sebastian Froelich
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Kagle
15. Birthplace: Germany

16. Informant: Edward Thomas Spiker
Address: Bx 298 R. F. D. 9, Margate, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 9, 1945 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: A. A. Co. Md.

18. Funeral director: A. Howard Evans
Address: 1400 Charles St. Balto

19. March 6 19 45 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 19 45, at 6:13 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 March 19 45, to 5 March 19 45 and that I last saw her alive on 5 March 19 45

Immediate cause of death	DURATION
Myocarditis, Chronic	
Due to: Arteriosclerosis	
Due to: Chronic and Subacute Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: R. Trance, Cmdr (MC) USNR
M. D. or other
Address: USN Hospital, Annapolis, Md. Date signed: 3-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85-A)

CERTIFICATE OF DEATH

02539

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1211 West St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jennie Culler Stanley

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Hiram Stanley
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Aug 7th 1886
8. AGE: Years 58 | Months 7 | Days 5 | If less than one day ____ hrs. ____ min.
9. Birthplace: Pinnacle N. C. (Town, county, and state)
10. Usual occupation: Pres. Coca Cola Bottling Co of Annapolis
11. Industry or business
FATHER 12. Name: Louis Culler
13. Birthplace: Pinnacle N. C.
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Ralph C. Stanley
Address: 1211 West St. Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mch 15 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.
18. Funeral director: John M. Taylor
Address: Annapolis Md.
19. Mar. 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 19 45, at 12:19 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1935, to March 13 1945 and that I last saw h.. alive on March 13 1945

Immediate cause of death	DURATION
Cerebral Hemmorhage	1 hr
Due to: Hypertension	10 Years.
Due to:	
Other conditions: Arteriosclerosis	10 years.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Boyd M. D. or other
Address Annapolis Md Date signed 3-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

02540

Reg. Dist. No. 38 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 5 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: STEWART - BELLE

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Balck	Widow

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1865

8. AGE: Years	Months	Days	If less than one day
80	unknown		--- hrs. --- min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Servant
11. Industry or business: ---

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof March 13, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Anne Arundel County

18. Funeral director: Mrs. George H. Holland
Address: 1631 Druid Hill Ave., Balto., Md.

19. Mar. 11, 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 19 45 at 3:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4 19 44 to March 9 19 45 and that I last saw her alive on March 9 19 45

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 11/4/44
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ---
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 3/9/45

02541

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs, 3 mos, 16 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 yrs, 3 mos, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Croome
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3. (a) FULL NAME: STEWART - JAMES ALFRED

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): August 28, 1898

8. AGE: Years	Months	Days	If less than one day
46	6	25	---- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ---

FATHER
12. Name: Andrew Stewart
13. Birthplace: Maryland

MOTHER
14. Maiden name: Irma Clark
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof 3 (month) 24 (day) 45 (year)
Cemetery or crematory: Mt Carmel
Location: Upper Marlboro
18. Funeral director: Ritchie Bros
Address: Upper Marlboro Md

19. 3/24 1945 (Date rec'd by registrar) E T Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 19 45 at 5:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7 19 38, to March 23 19 45
and that I last saw him alive on March 23 19 45

Immediate cause of death	DURATION
Lung Tuberculosis	Known to us since 1/10/41
Due to: ---	
Due to: ---	
Other conditions: Psychosis with Mental Deficiency	Known to us since 12/7/38

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Albert J Winfrock M. D. or other
Address: Crownsville, Maryland Date signed: 3/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

02542 25
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 minutes.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore City.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1230 - Hull St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs. Alma Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband or wife: Jas. H. Thompson
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Sept. 15 - 1898

8. AGE: Years: 45 | Months: 6 | Days: 16 | If less than one day: ....hrs. ....min.

9. Birthplace: Middlesex County - Virginia
(Town, county, and state)

10. Usual occupation: Housekeeping.

11. Industry or business:

FATHER
12. Name: James Davis
13. Birthplace: Virginia

MOTHER
14. Maiden name: Marguerite Foster.
15. Birthplace: Virginia.

16. Informant: Mrs. G. H. Thompson
Address: 1230 - Hull st - Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 4, 1945 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: C. A. C.

18. Funeral director: E. Howard Evans
Address: 1400 S. Charles St

19. 4/2/45 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 - 1945, at 7:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h.... alive on ....19....

Immediate cause of death	DURATION
sudden death to	
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Gustave A. Pander M.D. (Attending physician) (Coroner) M. D.
Address: Glen Burnie Md Date signed: 3/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02543

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft Geo G Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No. –
(If rural, give LOCATION)
2.(a) If veteran, name war –

3. (a) FULL NAME: Douglas L. THOMPSON

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): December 2, 1928

8. AGE: Years	Months	Days	If less than one day
16	3	12	– hrs. – min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: –

11. Industry or business: –

FATHER
12. Name: Deceased - 1937
13. Birthplace: Williamsport, Pa.

MOTHER
14. Maiden name: Louisa Miller (Thompson)
15. Birthplace: English Consul, Md.

16. Informant: Mother - Mrs. Louisa Thompson
Address: Gambrills, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 13, 1945 (month) (day) (year)
Cemetery or crematory: St. Stephens Cemetery
Location: Millersville, Md.

18. Funeral director: B L Hopkins
Address: Annapolis, Md.

19. March 13, 1945 (Date rec'd by registrar) W. J. Lawson Jr. Registrar
W.J. LAWSON, JR., 1st Lt., MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1945 at 9:27 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 8 1945 to March 13, 1945 and that I last saw him alive on March 13, 1945

Immediate cause of death	Broncho Pneumonia	DURATION 5 days
Due to		
Due to		
Other conditions	Bantis Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: –
Date of op.: –
Autopsy results: –

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of: –
Where did injury occur? – (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): –
Means of injury: – Injured at work? –

23. SIGNATURE: J. H. Clark Jr. M.C.
J. H. Clark, 1st Lt., MC M. D. or other
Address: Reg. Hosp Ft Meade Md Date signed: 3/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7a)

02544

CERTIFICATE OF DEATH

Reg. Diat. No. 70

1. PLACE OF DEATH
County: Anne Arundel
City or town: Woodland Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Woodland Beach Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No. or Rural: Cor. Laurel Rd. & Elson Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie E. Turner
3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Thomas C. Turner
6.(c) If alive, give age: 73 years
7. Birth date of deceased (mo., day, yr.): Dec. 20, 1880

8. AGE: Years	Months	Days	If less than one day
64	3	1	...hrs. ...min.

9. Birthplace: Popes Creek Charles Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Thomas Thompson
13. Birthplace: Charles Co. Md
MOTHER 14. Maiden name: Laura V. Proctor
15. Birthplace: Charles Co. Md
16. Informant: Thomas C. Turner
Address: Woodland Beach Edgewater Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof Mar 22 1945 (month) (day) (year)
Cemetery or crematory
Location: Hyattsville Md
18. Funeral director: Wm Gasch Son
Address: Hyattsville Md.
19. Mar 21 1945 (Date rec'd by registrar) Edward Colleson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1945 at about 3 P M
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post Mortem Examination 19... 19...
and that I last saw ~~him~~ ~~alive~~ on March 21 1945
Immediate cause of death: Coronary thrombosis — DURATION: Sudden
Due to: Coronary sclerosis — DURATION: Intermittent
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Coffey Deputy medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 3/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95d)

02545

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred:
Simms Crossing Parole Md.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Simms Crossing Parole Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Simms crossing, Wells Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: James Henry Wells

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

8.(b) Name of husband or wife: Mrs Elizabeth Wells
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 19, 1870

8. AGE: Years	Months	Days	If less than one day
74	5		..... hrs. ..... min.

9. Birthplace: West River A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: None
FATHER 12. Name: John Henry Wells
FATHER 13. Birthplace: A. A. Co. Md.
MOTHER 14. Maiden name: Frances Price
MOTHER 15. Birthplace: A. A. Co. Md.
16. Informant: James A. Wells
Address: Simms Crossing Parole Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/17/45 (month) (day) (year)
Cemetery or crematory: Fowlers Chapel Cemetery
Location: Best Gate Md.
19. Funeral director: Ethel L. Hicks
Address: 45 Northwest St. Annapolis Md.
19. Mar. 17 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 19 45 at 7:15 M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1, 19 43 to March 13 19 45
and that I last saw him alive on March 13, 19 45

Immediate cause of death	DURATION
Heart Failure	1 day
Due to: Chronic Myocarditis	3 Yrs
Due to:	
Other conditions: Arteri-Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. F. Richardson M.D. M. D. or other
Address: Route 5 Box 54 Annapolis Md. Date signed: 3/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

02546

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

1. PLACE OF DEATH:

County Anne Arundel

City or town Pasadena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Pasadena

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 Mill Road

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME William E. Wirth

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 9, 1927

8. AGE:

Years	Months	Days	If less than one day
18	0	14	..... hrs. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual occupation Farm help

11. Industry or business

FATHER 12. Name John E. Wirth

13. Birthplace Baltimore Md

MOTHER 14. Maiden name Edith Hall

15. Birthplace Mt Airy, Md

16. Informant John E. Wirth

Address 2 Mill Rd. Pasadena Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/24/45 (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore Md

18. Funeral director Wilhelm Funeral Home

Address 1217 Light St

19. 3/27/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March. 10 1945, to March. 23 1945 and that I last saw him alive on March 23 1945

Immediate cause of death	DURATION
Acute Blastic Leukemia	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas. L. Bale Jr M.D. M. D. or other

Address Linthicum Md. Date signed 3-23-1945